Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARY GONZALES, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TEXAS 77027

Respondent Name

UNIVERSITY HEALTH SYSTEM

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-11-2413-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION HAS BEEN SUBMITTED."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The dispute is in regards to the reimbursement amount for procedure code 99456W5WP initially billed for $650.00 for one unit then on reconsideration the billed amount was changed to $950.00 for three units. The bill was audited on December 14, 2010 and the reimbursement for procedure code 99456W5WP was $350.00 for the MMI portion and $150.00 for the impairment rating for a total of $500.00. The carrier received the second bill submission on December 16, 2010. The total amount billed was $1,465.00 for three procedure codes 99456REW8 ($500.00), 99080-73 ($15.00), and 99456W5WP ($950.00). Based on the documentation, the provider should not have billed and received a reimbursement of $300.00 for the invalid impairment ratings."

Response Submitted by: Argus Services Corporation, 9101 LBJ Freeway, Suite 600, Dallas, Texas 75243

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 20, 2010	99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services..
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 14, 2010 with payment of $500.00 on original bill of $650.00.
   - W1A – Workers Compensation State Fee Schedule Adjustment*Reconsideration per Rule 134.203/134.204. Prior to March 1, 2008, Rule 134.202.*

   Explanation of benefits dated December 21, 2010 with payment of $300.00 on amended bill of $950.00
   - W3 – Additional payment made on appeal/reconsideration.
   - W1A – Workers Compensation State Fee Schedule Adjustment*Reconsideration per Rule 134.203/134.204. Prior to March 1, 2008, Rule 134.202.*

   Explanation of benefits dated January 07, 2011
   - 193Z - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. *Thank-you for your inquiry. No additional reimbursement allowed after review of appeal/reconsideration.*
   - 193W - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. *Previous recommendation was accordance with the Workers' Compensation State Fee Schedule.*

   Explanation of benefits dated March 4, 2011
   - 193Z - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. *Thank-you for your inquiry. No additional reimbursement allowed after review of appeal/reconsideration.*
   - 193W - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. *Previous recommendation was accordance with the Workers' Compensation State Fee Schedule.*

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The provider originally billed the amount of $650.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the original documentation supports that MMI was assigned and one body area was rated. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. DRE method IR was used on spinal region which is one musculoskeletal area including lumbar and cervical per 28 Texas Administrative Code §134.204(j)(4)(C)(i)(I). Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) method on the spinal region is $150.00. The combined MAR for the MMI/IR examination is $500.00.

2. The requestor later submitted a "corrected" claim and changed the billed amount to $950.00 and the number of units on the billing reflecting an amended number of body areas tested to include bilateral range of motion for shoulders, ankles, wrists, and knees. The additional body areas where not eligible for reimbursement as there was no impairment given. For that reason, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 21, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.